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RESEARCH ARTICLE

FROM VICTIM TO VICTORS; WOMEN'S COMBAT PSYCHOLOGICAL SUFFERING AND GAINED WELLBEING AND RESILIENCY IN POST DISASTER SITUATION MORE MEANINGFULLY

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ABSTRACT

The present study examined the effect of Psycho social intervention on women survivor of the super cyclone. The sample consisted of survivors of the 1999 Super Cyclone. Three scales were being used for assessment. The experimental group 211 women and in control group 30 women were taken to conduct this research. The psychological first aid and psycho-social care services that formed a major part of intervention worked to the advantage of the disaster-affected subjects in that their energy level increased, the somatic complains were reduced and the experience of depressive mood and thought went down and their self-evaluation of their quality of life in the family as well as in the community turned to be positive for both males and females. One noticeable aspect was that the control group also gained partly because health care services were also provided to them and partly because of the "spread-off effect" of intervention as they were sharing the same community with the experimental group. The use of substance was not marked in this sample as the stress impact after disaster. Hence, it is observed that women and more constructive and positive attitude towards re building and became in true sense from "Victim to Victors", "journey was not smooth but not impossible" as expressed by a survivor. The findings revealed significant effect of intervention on the women resilience building. Positive reconstructive sustainable wellbeing was marked significantly. Because of the "Placebo effect" on the same community life shared by the experimental and the control group there was a "spread-off effect" of the benefits of intervention to some extent for the control group as well.

Key words: Women, Survivor, Psychological morbidity, depressive, social, wellbeing, spiritual and self care, quality life and community.

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INTRODUCTION

The super cyclone in Orissa in October 29, 1999, perhaps the most destructive natural calamity in India in this century with a wind speed of nearly 300kms and incessant rains that lasted for about 48 hours with a total downpour between 447 mm and 995 mm and tidal waves from the sea reaching to 10 meters struck the Orissa coast coming almost 15kms inland, washed away everything which came under its flow. There was massive damage to houses, vegetation, livelihood and the environment. Over 15 million people in the 12 districts were affected. Almost 20 000 persons were killed. The total estimated damages were 39680 million INR (Source: Government of Orissa). On the 6th of December, the revenue department of the state Government issued a 'white paper' on the loss and damage to life and property due to the super cyclone.

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According to the white paper, there were 9885 deaths; with 8386 people died in Jagatsinghpur district alone of which 8119 deaths was reported in Erasama Block. There were 262 deaths in Balikuda Block. Figures for loss of livestock were kept at 315886 cattle, 316372 other animals such as goat, sheep, pig etc. and 18833467 fowl. About 1650086 houses have been damaged because of cyclone as well as the ensuing flood. Almost 14901 primary school, 3425 high school buildings and 66 colleges were damaged. 12000 km roads, 1447 bridges were damaged. Electricity supply to most villages was disrupted. Considering the loss of standing crop, 1300000 hectare of paddy, 176000 hectare of vegetable crops and 257000 hectare of other crops were lost. 2 million trees were uprooted. There was extensive saline incursion in agricultural fields. Crop loss was estimated at around 17.5 million. The vulnerability profile of Odisha is needed to consideration as it shows Odisha is located between the parallels of 17.49N and 22.34N latitudes and meridians of 81.27E and 87.29E longitudes. It is bounded by the Bay of Bengal on the east; Chhattisgarh on the west, Jharkhand and West Bengal on the

north and Andhra Pradesh on the south. It has a coast line of about 480 km. It extends over an area of 1, 55,707 square km covering about 4.87% of the total area of India. According to the 2011 census, it has a total population of 4,19,47,358 (3.73% of the total population of India) out of which about 2,12,01,678 are men and 2,07,45,680 are women. In response to the super cyclone, the Government and Non Government agencies came forward for rescue, relief and rehabilitation of the affected in a concerted way. Like other agencies Action Aid India also resolved to contribute to this massive reconstruction effort. The rehabilitation attempts in the early days made Action Aid India to realise the dangers of inadequate importance being given to the psychosocial stressors following the disaster. The focus consequently was strengthened on the prevention and management of the psychosocial consequences of disasters. Thus came into being the concept of Sneha Abhiyan. The psychological First Aid and Psychosocial Intervention was a response to ensure rehabilitation of the most vulnerable among the survivors of the Orissa super cyclone - children, women and old people who are left without the care of families and people who were under severe psychological shock and depression. Aimed at long-term community based rehabilitation (CBR) of the most vulnerable survivors of the tragedy this initiative has been implemented (Gupta, (2001)). It is found that women are the worst living survivor, whose losses are huge in respect of property, life and livelihood. The women group provided PFA as an alternative to "psychological debriefing" which has been found to be ineffective. In contrast, PFA involves factors that seem to be most helpful to people's long-term recovery (according to various studies and the consensus of many crisis helpers. These includes i.e. feeling safe, connected to others, calm and hopeful; having access to social, physical and emotional support; and feeling able to help themselves, as individuals and communities. The survivors People who need more immediate advanced support, people with serious, life-threatening injuries who need emergency medical care, people who are so upset that they cannot care for themselves or their children, people who may hurt themselves, people who may hurt others (Parthasarathy 2003).

When it is advisable to provide support in form of PFA is usually during or immediately after an event. However, it may sometimes be days or weeks after, depending on how long the event lasted and how severe it was (WHO 1998). Helping responsibly involves four main points was taken to consideration based on ther field testing and research evidence i.e. Respect safety, dignity and rights, Adapt what you do to take account of the person's culture, Be aware of other emergency response measures, Look after yourself and Respect people's space. *Safety* - Avoid putting people at further risk of harm as a result of your actions. Make sure, to the best of your ability, that the adults and children are safe and protect them from physical or psychological harm. *Dignity* - Treat people with respect and according to their cultural and social norms. *Rights* - Make sure people can access help fairly and without dis crimination. Help people to claim their rights and access available support. Act only in the best interest of any person you encounter (Sekar, K and Bhadra 2003). Prepare to learn about the crisis event, Learn about available services and supports and Learn about safety and security concerns.PFA Action Principles are 3Ls: Look to check for safety, Check for people with obvious urgent basic needs, Check for people with serious distress reactions. Listen to approach (Prewitt Diaz 2003) people who may need support, ask about people's needs and concerns and listen to people and help them to feel calm. Link to help people address basic needs and access services, help people cope with problems, give information and connect people with loved ones and social support. Ethical do's and don'ts are offered as guidance to avoid causing further harm to the person, to provide the best care possible and to act only in their best interest. Offer help in ways that are most appropriate and comfortable to the people you are supporting. Consider what this ethical guidance means in terms of your cultural context. We offer the following Ethical Do's and Don'ts as guidance to avoid causing further harm to the person, to provide the best care possible, and to act only in their best interest (Sekar, 2003). While PFA was given the Do's followed were being honest and trustworthy, respect people's right to make their own decisions, be aware of and set aside your own biases and prejudices, make it clear to people that even if they refuse help now, they can still access help in the future, respect privacy and keep the person's story confidential, if this is appropriate and behave appropriately by considering the person's culture, age and gender. While PFA was given the Don'ts followed were being sensitive not to exploit your relationship as a helper i.e. Don't ask the person for any money or favour for helping them, Don't make false promises or give false information, Don't exaggerate your skills, Don't force help on people, and don't be intrusive or pushy, Don't pressure people to tell you their story, Don't share the person's story with others, Don't judge the person for their actions or feelings. People who need more than PFA alone are some people will need much more than PFA alone. Know your limits and ask for help from others who can provide medical or other assistance to save life (Gerard A. Jacobs, 2003). People who need more advanced support immediately: People with serious, life-threatening injuries who need emergency medical care, People who are so upset that they cannot care for themselves or their children, People who may hurt themselves, People who may hurt others.

In the general adult population, the normal prevalence rate of mild to severe forms of mental disorders is estimated to be about 2% to 3%. WHO (2005) estimates that as a consequence of encountering catastrophic and emergency situations, the 12-month prevalence rate following the disaster is approximately 10% for mild disorders (mild forms of depression and anxiety) and 15-20% for moderate disorders (moderate forms of depression and anxiety disorders, including PTSD) and 30-35% for severe disorders (psychosis, severe depression, severely disabling form of anxiety disorder etc.) Mental disorders make a substantial contribution to the Global Burden of Disease (GBD). Neuropsychiatric conditions account for nearly 14% of the global burden of disease (WHO, 2001), which multiply after disaster and/or any personal crisis or emergency situation. New comprehensive mental health action plan 2013-2020 as a landmark achievement focuses international attention on a long neglected problem and is firmly rooted in the principles of human rights. (Chan, the WHO Director-General).Disaster intervention with a holistic perspective should be implemented for the most vulnerable, taking care of their economic as well as psychological and social needs into account (Joseph Prewitte Diaz, 2006). Mental disorder as a mental condition that causes significant distress or disability, is not merely an expected response to a particular event, and is manifestation of a mental dysfunction. It gives a framework for supporting people in ways that respect their worth to self help and resilience building (Wakefield, 1992). People are understandably distressed, having often lost

loved ones as well as a sense of security and safety. PFA involves normalizing a person's response to a crisis situation as well as linking with services (Andernach, 2010). Disaster mental health issues are serious and pervasive mood disorder. It causes feelings of sadness, hopelessness, helplessness, and worthlessness. Depression can be mild to moderate with symptoms of apathy, little appetite, difficulty in sleeping, low self-esteem and fatigue. Or it can be more severe and leads to PTSD. Rapaport, Clary, Fayyad and Endicott (2005) have shown that subjects with depression who enter clinical trials have significant quality-of-life impairment, although the degree of dysfunction varies. The interview data show a picture of dependence, fatalistic orientation and lack of any significant initiative for development despite the huge economic input through the relief and rehabilitation programmes operating for over six months after the super cyclone (Mohanty 2003).

Objectives

- To study the overall impact of the disaster on the survivors of Super cyclone in relation to their gender and intensity of loss background.
- To study the impact of Psychological First Aid (PFA) Intervention on the perception of the disaster survivors regarding their physical and mental health.
- To assess impact of PFA intervention on the quality of life and community life of Female disaster survivors.
- To ascertain the harmonizing life with behavioral changes in respect of abilities of women to cope with the situation for stress management, PSC therapy, spirituality and self care.

MATERIALS AND METHODS

Design: The present study examined the aspects on disaster mental health of the women. The effect of psychosocial intervention on psychological morbidity, individual's quality of life and quality of life in the community following a 2 (Group: Experimental vs. Control) X 2 (Gender: Female vs. Male) X 2 (Testing Phase: Pre vs. Post) factorial design with repeated measures on the last factor.

Sample: The sample consisted of disaster survivors of Erasama, Jagatsingpur affected by 1999 Super Cyclone. On the basis of the Scores on the Impact of Event Scale administered to 685 subjects, 211 women in experimental group subjects experiencing high impact and psychological morbidity constituted the sample for the study. And the Control Group included 50 females. Table 1 gives the demographic characteristics of the sample.

WHO SRQ assessment of Psychological morbidity: Consisting of 4 major domains decreased energy, somatic complain, depressive mood and depressive thought, This has been developed by WHO as an instrument designed to screen for psychiatric disturbance, especially in developing countries. This concentrates on the SRQ-20 only of the "neurotic" items, which has to be answered by 'yes' 'r 'no'.

Quality of Life (QoL) BREF: QOL-BREF consists of 28 items for understanding the individual level satisfaction having 4 major domains - physical, psychological and social relations and environment. The questions are simple and can be self-administered or by an interviewer. This instrument has been extensively used in a large number of countries and in India.

Quality of Community Life (ICMR-QoCL): QOCL is a 33-item scale developed by the Indian Council of Medical Research. The instrument has 11 indicators such as colleagues, community efforts, relatives, family, neighbors, friends, medical and other facilities, social discrimination, social contact, law & order and caste and religion.

Procedure

The study was conducted over a period one and half years, as per the subjects mood and emotion taken into consideration. During which the villages were visited and also the data collected from the team from NIMHANS. The villagers were contacted either in their homes or in some common community location such as schools or shelter homes (Mamta Gruha) for destitute women and children. The respondents were told about the purpose of the study and were assured about the confidentiality of their views and opinions. Very often it was not practical to isolate the individual respondents for an interview which, in such cases, had to be conducted with some other villagers overlooking and overhearing (sometimes even prompting) the interview session. This was accepted as a normal aspect of rural life in which an individual's opinions and attitudes are shaped by a collective pressure. Each interview session lasted for about 45 to 1 hour, including the initial conversation to establish rapport. The visits took place during the daytime. Subjects were selected from the victim of Super Cyclone in Odisha. Before the administration of test, subjects were thoroughly instructed about the tests and all their queries were answered. The Impact of Event Scale R was administered to the victims of Super cyclone of Erasama Block. Those experiencing extreme losses were selected from the result out of impact of event scale and explicit psychological suffering and morbidity based on the score secure in avoidance (numbing of responsiveness, avoidance of feelings, situations, and ideas), and hyperarousal (anger, irritability, hyper vigilance, difficulty concentrating, heightened startle), as well as a total subjective stress IES-R score. The sample was of different age groups and gender i.e., women & men from one locality depending on the severity of loss due to Super Cyclone and was immensely affected psycho-socially on the disaster mental health aspects.

Table 1. Demographic Characteristics of the Sample, (N Female = 211 in Experimental and 50 control group)

Age in years		Family Size		Monthly income (In Rs)				Education (In years)	
				Pre cyclone		Post Cyclone			
Mean	Range	Mean	Range	Mean	Range	Mean	Range	Mean	Range
34.91	18-60	6.09	2-16	2,557.32	700 to 5,000	382.93	0-2,000	2.70	0-10

Tools: Three questionnaires were used to collect data from the subjects in the present study. All subjects were assessed on the following scales;

Impact of Event Scale: Impact of Event Scale Items (IES-R) are rated on a 5-point scale to access the impact of the Disaster on the survivors. The IES-R yields a total score ranging from 0 to 88.

Table 2. Summary of ANOVA showing the effects of group, gender and testing conditions in WHO-SRQ on Psychological morbidity, Quality of life and quality of Community life

Source	WHO SRQ-F	QoL - F	QoCL - F
Group (A)	40.25**	2806.48**	69.97**
Gender (B)	62.86**	13.24**	2.48
A X B	.42	36.21**	.33
Error			
Testing Condition (C)	501.55**	35575.44**	8929.26**
A X C	153.16**	140.69**	6.32**
B X C	34.94**	14.43**	3.76*
A X B X C	.47	40.52**	.85
Error			

Table 3. Vulnerability matrix of women survivors

Why a widow is more vulnerable than a widower? – People's perception

- Biological vulnerability restricts her mobility
- Lack of knowledge about the institutions and systems in the public domain
- Lack of knowledge about the family assets/ properties
- Lack of knowledge about her legal rights and how to access it
- No outlet for sharing and ventilating apprehension or fear
- Social rituals put restriction on a widow and not on a widower resulting lack of confidence in a widow
- No previous experience or exposure on money management
- Lack of literacy in most cases makes them dependent on men for any formal procedures requiring use of letters

Table 4. Psychological morbidity among women adults

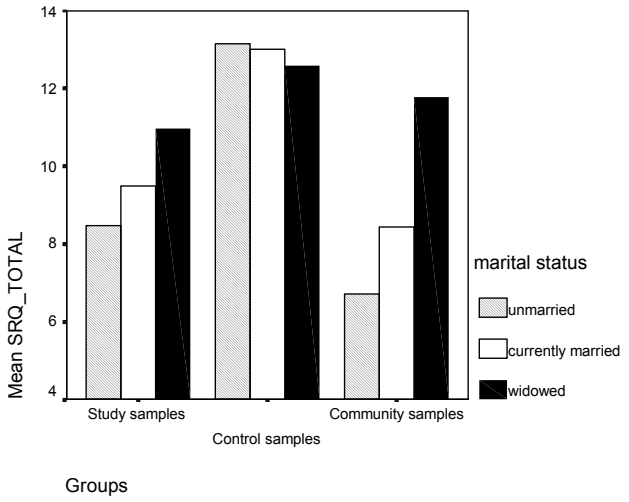
Psychological symptoms	Positive responses n(N=591)		Differences between centres
Head ache	320	(54%)	Nil significant
Poor appetite	252	(43%)	Nil Significant
Bad sleep	260	(44%)	Significant difference 0.01 level
Easily frightened	216	(37%)	Nil Significant
Hands shake	152	(26%)	Nil Significant
Nervous, tense, worried	453	(77%)	Significant difference 0.01 level
Poor digestion	210	(36%)	Nil Significant
Trouble thinking clearly	226	(38%)	Nil Significant
Feel unhappy	501	(85%)	Significant difference 0.01 level
Cry more	382	(65%)	Significant difference 0.01 level
Difficulty enjoying daily activities	278	(47%)	Significant difference 0.01
Difficulty to make decisions	284	(48%)	Significant difference 0.01
Work suffering	371	(63%)	Significant difference 0.00
Useless in life	352	(60%)	Significant difference 0.00
Lost interest in life	334	(56%)	Significant difference 0.00
Worthless person	351	(59%)	Significant difference 0.00
Ending life	278	(47%)	Significant difference 0.00
Tired all the time	344	(58%)	Significant difference 0.00
Uncomfortable feeling stomach	200	(38%)	Nil Significant
Easily tired	337	(57%)	Significant difference 0.00

The subjects reaching temporary Shelter homes "Mamata Gruha", Erasama and diagnosed as having psychiatric complain and psychological morbidity were interviewed at a separate place in the community. Data collection was done under the supervision of the psychiatrist mental health professionals from NIMHANS. Both the groups had the same level of experienced trauma. The subjects were accompanied by the community member, family members or relatives or friends who were requested to clarify issues when the subject failed to answer. The data collection process took about one and half -year depending on the mood and preparedness of the subject.

RESULTS

The scores on WHO-SRQ, QoL and QoCL of the survivors were statistically analysed. The result found as shown in the table above. The main effects of Group and Testing phase and their interaction were significant for the total 'Quality of Community Life' Score suggesting that intervention improved the quality of Community life of both females as well as males. The main effects of Group and Testing phase and their interaction were significant for the total 'Quality of Community Life' Score suggesting that intervention improved the quality of Community Life of both females as well as males. The explanation invoked for quality of life may also be applicable to explain the improvement in the quality of community life for the experimental and the control Group. Both gained because of spread-off effect as they were sharing the same community life. Position and status of women as similar as in a traditional patriarchal conservative society, women in the study area were confined to the four walls of their house and land. For most of their outside interaction and information they were dependent on the male members of the family, be it the husband for the married women, or the father or brother in laws for the widows or father or brother for the adolescent girls. Suddenly after the cyclone when they have been thrown into the public domain for their survival, the vulnerability and stress of the women without any man's support is very high. This perceived lack of adult men's support has also rendered the minor orphans equally vulnerable. The vulnerability analysis by all focused groups in

all villages has yielded the same opinion. (Vulnerability matrix) in Table 3 below. Some limitation was experienced during the intervention System problems:



Graph 1. Marital status and psychological morbidity scores.

Lack of adequate communication, frequent change of policies for relief, irregularities in availability of assured relief or benefit were some of the problems. In addition lack of periodic training of the counsellors, lack of arrangement for a referral system for the needy victims, unavailability of professionals to address the changed needs of the victims and volunteers were the factors often quoted as hindrances for effective intervention. The mean psychological morbidity scores for the widowed were higher in the intervention area. Whereas, in the non-intervention area it was seen that the mean score is almost the same for all the marital statuses considered for the study. Further there is a reduction in the mean range of score observed for the intervention area in comparison to the non-intervention area. Overall health rating of the samples was reportedly average to poor according to 70% of the samples.

DISCUSSION AND CONCLUSION

In most of the widow remarriage cases this perceived vulnerability due to absence of a male support in the family has driven the women to seek solace from a male neighbour or relative, gradually leading to intimacy and sexual interaction. Some women entered into physical intimacy as a mark of gratitude, some with the hope that the physical intimacy would lead to some kind of permanency to the relationship. There are even cases where women entered into physical intimacy to beget a child. But in almost all cases of these new relationships, women have parted with a large share of their exgratia compensation or are under different kinds of pressure from the male counter parts to shell out the amount. In most of these relationships women feel they are unhappy, suppressed.

In certain cases women are enduring physical violence for not parting with the money. Though the general community perceives the families without adult men's support as socially vulnerable and but are jealous of the perceived better off economic status of these women due to the exgratia compensation received for the dead family members. In Erasama men were overall sympathetic to these vulnerable groups, but their antipathy came out when a group complained, "till the cyclone most of these families were dependent on us. Even after cyclone we have helped them. But because of our financial difficulty these days sometimes we have to lose our face and ask for help from these women. As if this is not enough these people are even asking for some security before lending any amount to us."

Economic aspects: Non-revival of traditional livelihood: The community's economic life was supported by a wide variety of livelihood patterns. Cultivation, along with fishing along the coast and in prepared fresh water ponds was widely practised. Staple food cultivation was dominated by paddy, but vegetable and fruit crops were also important. Betel vine, coconut and cahsewnut were the main cash crops supplementing the family income. Prawn farming was also practised by some. Animal husbandry was also a major source of subsidiary income. Coping mechanism till date: Relief: Immediately after the cyclone, relief of food items was the source of sustenance. For the first couple of days people starved. Then people in many places had dug out wet, muddy rice beneath the decimated houses and washed it with the flowing water with floating animal corpses and human dead bodies and survived on that. External relief of food packets reached the villages after three to five days. Relief measures in terms of cooked food and dry foods were the source of sustenance for around one and half months.

The single survivors in all the study villages narrated their difficulty in accessing the relief during that period. In no place women had gone to access the food relief to the panchayats. Only men had accessed the items. But if relief was being distributed in their own village some women had gone out to get the share for their family. Women and men in Erasama both analysed the reasons for lack of access of single women to the relief like the following: The women did not know as to where to go to get the relief, they were afraid and shy of going to a place which would be crowded with alien men, There used to be unruly scene and the occasional use of muscle power to get a larger share by the men. Men who used to get large shares were rather appreciated in the family and the village for being a better provider. If a woman would have done that, she would have been looked down upon for 'the untoward behaviour'. Single women lacked even the will to survive and in cases showed no interest to get the relief. They were more interested in searching for the missing ones. Food for work: While the relief measures came down after a few months, the need for basic amenities still continued. Since then till date food for work has been instrumental in providing employment and food security to the people in these areas. Support to individuals for income generating activities: The lack of experience or adequate skill to do the activity, the lack of forward and backward linkage for the activity to generate profit and the lack of expert support services in the vicinity Problems and worries: As has been mentioned the people have been coping with the help of FFW and relief food till date and the non-revival of tradition livelihood system had not really bothered them till date. Problems in providing psychosocial care At the level of Community Level Workers/SKs were Most of the SKs/CLV felt inadequate in knowledge while handling difficult cases, They felt inadequate in group-counselling, Self Doubt / Guilty feeling of the SKs, Frequent shift of the SKs to various places had hampered continuity of care, Gradual decrease in motivation in some SKs because of lack of guidance, Some SKs felt the need to open up and to be listened to, gender, age related difficulties in communication, gossips and suspicion in the society about different motives (sexual, etc.) of the SKs, lot of responsibilities of relief materials, their distribution and tackling, lack of adequate time for

psychosocial intervention, transference issues like considering the victims as family members. Formation of WSHG by the survivors also creates confidence and psychological well being for sustainable empowerment of the women in post disaster situation. At the level of recipients the limitations were Most of the ladies were shy, some were crying inconsolably. A few were mute, there was social inhibition in talking to the outsiders, Taboo against psychological help also played some role. Some were very argumentative, quarrelsome suspecting the motives of counsellors. There were un-cooperativeness if financial expectations are not met. Some were unmindful of the discussion or guidance. Many victims showed lack of enthusiasm, as improvement was not so quick. Many were not able to see the reason for counselling even if explained repeatedly.

At the level of Community Discrimination against ladies and discomfort with women empowerment, Negative discouraging comments, threats for the counsellors and their work. Self Help Groups that made the ladies aware of their rights, and increased their self esteem often voiced against corruption. Barriers to providing psychosocial care was that the attitude of the general public towards women was often cited by most of the SKs as a barrier to psychosocial counseling in this part. Food for work was not uniform in different areas: which was bringing in discretionary treatment to victims. This was not helping in developing rapport with some victims. For sustainability effect the importance was given on spirituality, harmonization of family life and self care by Abdominal breathing, Count breathing, Relaxation breathing, Variations, Meditation, Yoga, Free meditation. These techniques if practiced regularly can help in calming and enhancing our ability to cope with the demands of the day. It is best suited for early mornings or in the evenings after the day's work is over.

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